Homicide Laws

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ABSTRACT

After several cases in which pregnant women were forced to undergo cesarean sections under court order or where court orders were sought for cesarean sections, the medical community reaffirmed the principle of autonomy for pregnant women. Women are allowed to refuse care during pregnancy, even if that means harm to the fetus. In addition, it is inappropriate for medical personnel to seek legal assistance in forcing a woman to accept treatment. This article presents a case in which the medical community upheld the woman's right to refuse care; however, the legal community then charged her with criminal homicide under the state's fetal homicide law because the baby was stillborn after the patient delayed in obtaining a cesarean section. The differences between medical guidelines and state law must be addressed so that the patient's autonomy is upheld and so that patients may be informed of all consequences, medical and otherwise, of refusing treatment.

INTRODUCTION

Significant discussion of the rights of women during pregnancy followed several cases in the 1980s and 1990s in which women refused treatment, usually a cesarean section, which was believed to be absolutely necessary in order to continue the fetus' life. The dispute surrounded the tension between a woman's right to autonomy and a fetus' right to life. The debate was eventually settled in favor of a woman's autonomy and granted her nearly limitless ability to refuse any medical treatment if she so desired. In addition, it was made clear that a woman could not be forced to accept treatment by either coercion or direct court order. The American College of Obstetricians and Gynecologists (ACOG) states, "Obstetricians should refrain from performing procedures that are unwanted by a pregnant woman. The use of judicial authority to implement treatment regimens to protect the fetus violates the pregnant woman's autonomy and should be avoided" (ACOG, 2004). The justification for this position is founded on several things, including the principle of patient autonomy, the need to keep fetal rights from becoming superior to those of all other patients, the avoidance of perverse incentives, and the difficulties in enforcing the duties of pregnant women.

The Unborn Victims of Violence Act (UVVA) of 2004 provides protection for fetuses harmed during military or federal crimes. In addition, 30 states have passed their own fetal homicide laws providing various degrees of legal status for fetuses. The UVVA states, "Whoever engages in conduct that violates any of the provisions of law...and thereby causes the death of, or bodily injury to, a child who is in utero at the time the conduct takes place, is guilty of a separate offense under this section" (UVVA, 2004). However, it adds the provision, "Nothing in this section shall be construed to permit the prosecution...of any woman with respect to her unborn child" (UVVA, 2004). Various state laws, however, do not provide such exemptions, and have opened the door to prosecution of women who refuse medical treatment while pregnant. Marshall Wilde from the University of Houston Health Law and Policy Institute comments, "There is no consistent message coming out of either state or federal courts with regards to the liability of a mother for the death of a child from failing to consent to medical treatment" (Wilde, 2003).

CASE

Ms. R, a 28 year-old gravida 4, para 4-0-0-5 with a twin intrauterine pregnancy at 38 weeks by last menstrual period, presented to her doctor with concerns about decreased fetal movement. Subsequent ultrasound showed oligohydramnios as well as intrauterine growth retardation of both twins. Fetal heart rates for both twins were in the 120s with decreased long-term variability and occasional variable decelerations. The physician recommended immediate cesarean section, but Ms. R declined. She returned for evaluation four times in the next several days; each time, immediate delivery was recommended and each time she refused. Eleven days after initial presentation, Ms. R consented to a cesarean and two infants were delivered. Twin A, a boy, was stillborn. Twin B, a girl, weighed two pounds, one ounce and had APGAR scores of two and five. Ms. R was then charged with criminal homicide in the death of Twin A. Two months after her indictment, she reached a plea agreement with the district attorney in which she

pled guilty to " two third-degree felony counts of child endangerment" (Thiessen, 2004).

DISCUSSION

Patient Autonomy

Perhaps the most fundamental argument for a woman's right to choose all medical treatment during pregnancy is that of patient autonomy. Autonomy—the belief that "every human being of adult years and sound mind has a right to determine what shall be done with his own body"—is a founding principle of American medical ethics (Hébert, 1996). Thus, a competent pregnant woman has the choice to refuse any medical care recommended, even if that choice results in the death of her fetus. The Court of Appeals in *In Re A.C.* made this principle clear. "Neither the viability of the fetus nor the potential harm to it are factors that can be used to justify overriding the woman's wishes, nor is the fact that the intrusion on the woman might be deemed small given her health condition" (Thornton and Paltrow, 1991). The Appellate Court of Illinois upheld this position in *In re: Baby Boy Doe v. Mother Doe*, in which the court stated, "A woman's competent choice to refuse medical treatment as invasive as a cesarean section during pregnancy must be honored, even in circumstances where the choice may be harmful to her fetus" (1994).

Fetal Rights Are Not Superior

There are no provisions under current law that mandate that someone must undergo invasive medical treatment in order to save someone's life. For example, a father is not required to become a living kidney donor in order to save his child from renal failure (Colb, 2004). This principle was established in *McFall v. Shimp*, in which Shimp was not forced to undergo a bone-marrow transplant to save the life of his cousin, McFall, although Shimp was the only matched donor available. The court stated, " one human being is under no legal compulsion to give aid or to take action to save another human being or to rescue" (1978). Likewise, a mother cannot be forced to endure any medical treatment for the sole purpose of benefiting the fetus. Some argue that requiring a pregnant woman to undergo a surgical procedure is unconstitutional, equivalent to targeting a group based upon gender or race or nationality. Sherry Colb, professor at Rutgers Law School, addresses this issue.

> An example? It is difficult to invent one, but let us use our imaginations. Say a hypothetical (but devastating) disease—fabricitis—is quite common. Say also that the disease can be cured completely with the injection of liver cells from men of Finnish descent. The liver cells must be extracted from the men before they reach the age of 45, though, and the only way to accomplish the extraction is through abdominal surgery. The criminal law could not demand of Finnish-American young men that they undergo the surgery to save victims of the disease. (2004)

Perverse Incentives

The medical establishment has avoided seeking legal support that would require a woman to complete any recommended treatment, because it is feared that she might give up prenatal care altogether. David Orentlicher describes this situation as a "perverse incentive."

A legal duty may be counterproductive to its primary goal of enhancing the health of fetuses and therefore children. If a pregnant woman fears that unwanted treatment will be imposed, she might avoid the health-care system entirely during her pregnancy, or she might terminate the patient-physician relationship with her obstetrician once unwanted treatment became an issue. As a result, her fetus might be worse off than if there were no legal duty (2001).

Difficulties with Enforcement

Pregnant women are given a long list of things they *should* do during pregnancy to ensure a positive outcome—eat a balanced diet, exercise regularly, take prenatal vitamins, and abstain from smoking, drinking alcohol, and using any illicit drugs. While these are things most doctors agree women ought to be doing, no one is forcing women to comply with these directives. Similarly, a doctor might firmly believe that a cesarean section is in the best interest of the fetus. "If a woman is obliged to protect her fetus from harm by having a cesarean, then it is not unreasonable to suppose that she might also be obliged to stop smoking to that same end" (Draper, 1996). Most Americans would find that to be an unreasonable infringement upon personal freedom, just as they would agree that a woman should not be required to follow a prescribed diet during pregnancy. While a cesarean generally deals with life or death rather than low birth weight or low IQ, it still constitutes an infringement upon a woman's body and freedom. "So long as the fetus is attached to the pregnant woman, her body maintains its life and bars access to it" (Ludwig, 1999).

Current Conflicts

These arguments and other supporting arguments have combined to create the current standards of practice in obstetrical care and have been upheld in numerous court cases throughout the country. However, a recent court case indirectly challenges this standard. In the case of *State of Utah v. MacGuire*, Martin MacGuire was charged with two counts of criminal homicide after shooting his ex-wife four times, causing her death and the death of the 13-week fetus she carried. The Utah Supreme Court upheld the charge of homicide in regard to the fetus, stating, "A person commits criminal homicide if he intentionally, knowingly, recklessly,

with criminal negligence, or acting with a mental state otherwise specified in the statute defining the offense, causes the death of another human being, including an unborn child" (2004). An exception was noted in the ruling for death of a fetus resulting from a medical or surgical abortion.

It is under this case that Ms. R was prosecuted for the death of her unborn child. The difference between the actions of Ms. R and MacGuire are that Ms. R's fetus did not die by her hand; rather, it was stillborn secondary to her failure to follow medical advice. Had she plunged a knife into her abdomen with the intent to harm her child, the cases would be parallel. However, she did not act with the specific goal of killing her fetus. Instead, she exercised a standard right of medical practice to choose what care she received. A cesarean section is not without risks to the mother, and is not offered on a purely elective basis because of those risks. General anesthetic poses risks to any patient, and surgical complications of a cesarean include injury to the uterus, bowel, or bladder. Common postoperative complications include infection, hemorrhage, atelectasis, urinary tract infection, and deep vein thrombosis/pulmonary embolism. In addition, women who have had cesarean sections are at increased risk of small bowel obstruction secondary to adhesions, wound dehiscence and placental accreta or increta with subsequent pregnancies (Danforth et al., 2003).

CONCLUSION

Physicians have long recognized the internal struggle that exists when a pregnant woman refuses recommended medical care, especially in the emergency setting. An obstetrician feels the obligation to act on behalf of both the patients—mother and baby. Nevertheless, situations arise in which the interests of the two are in conflict and the mother's autonomy must be balanced with the fetus' life. While fetal homicide laws may have a place in the legal system for prosecution when fetuses are injured during criminal acts, there must be clarification about the right of women to make decisions about their health care. For Ms. R to be prosecuted under such a law violates established medical practices and infringes upon her autonomy as a person. In the Kaiser Daily Reproductive Health Report, Kent Morgan, deputy Salt Lake County prosecutor, stated in discussion of Ms. R's case, "These cases we review on a case-by-case basis. If a mother causes the death of an unborn child in an unlawful way, she may well be facing murder charges" (2004). What Morgan fails to address here is that Ms. R did nothing unlawful. She simply took charge of her own health care, and made her own choices. While those choices had heartbreaking and tragic consequences, this does not constitute lawbreaking or murder. Marguerite Driessen, a law professor at Brigham Young University, states, "It's very troubling to have somebody come in and say we're going to charge this mother for murder because we don't like the choices she made" (Z, 2004).

The current dissonance between medical practice and state laws must be resolved so as to provide clear and appropriate guidelines for physicians and patients in these difficult situations. State laws should be amended with exemptions similar to those found in the UVVA. A clearly worded exemption providing for choice for pregnant women making health-care decisions will reduce much of the confusion and uncertainty that exist under the current fetal homicide laws.

In the meantime, physicians and patients must be made aware of the legal precedents that protect patients' autonomy. In addition to numerous court rulings, organizations such as ACOG have policies that uphold a woman's right to deny procedures.

Pregnancy is, for the most part, a happy and exciting time. Nevertheless, there are dangers and complications that can provide challenges for parents and physicians alike. Well-informed participants, strong communication and a harmonious relationship between the health-care and the legal communities can serve to make these difficult times less demanding for all.

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